



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name and Address**

RICARDO C SCHACK MD  
PO BOX 202212  
DALLAS TX 75320

**Respondent Name**

TWIN CITY FIRE INSURANCE CO

**Carrier's Austin Representative**

Box Number 47

**MFDR Tracking Number**

M4-10-3298-01

**MFDR Date Received**

March 19, 2010

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Did not exceed referral."

**Amount in Dispute:** \$ 1,491.05

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Continued billing of CPT 99234, 99244 does not support level of service per review of medical documentation."

**Response Submitted by:** The Hartford

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2009 through July 21, 2009	99243 and 99244	\$1,214.25	\$0.00
October 27, 2009	99244	\$276.80	\$276.80
TOTAL		\$1491.05	\$276.80

**FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 165 – Payment denied/reduced for absence of, or exceeded referral. Reimbursement has been denied because the provider is not approved for payment.
- W12 – Extent of injury not finally adjudicated. Reimbursement withheld – charge unrelated to compensable injury.
- W11 – Entitlement to benefits. Not finally adjudicated.

Explanation of benefits for date of service March 30, 2009:

- 50 – These are non-covered services because this is not deemed a medical necessity by the payer. Unnecessary treatment (without peer review).

Explanation of benefits for date of service October 27, 2009

- B16 – Paymt [sic] adj new patient qual [sic] not found. Follow up visits in the consultations office or other outpatient facility for the purpose of providing ongoing care should be reported using office visits codes for established patients.

### **Issues**

1. What is the appropriate process to resolve Compensability, Extent of Injury and Liability for dates of service April 17, 2009, May 22, 2009, June 5, 2009, June 30, 2009 and July 21, 2009?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
4. Did the requestor resolve the medical necessity issues for date of service March 30, 2009, CPT code 99243 prior to the submission of the Medical Fee Dispute?
5. Did the requestor submit documentation to support the billing of CPT codes 99244 rendered on October 27, 2009?
6. Is the requestor entitled to reimbursement?

### **Findings**

1. Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of compensability, extent-of-injury or liability for dates of service April 17, 2009, May 22, 2009, June 5, 2009, June 30, 2009 and July 21, 2009 for which there is a medical fee dispute.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that compensability, extent-of-injury and liability disputes be resolved prior to the submission of a medical fee dispute for the same services.

Compensability, Extent-of-injury and Liability dispute process: The appropriate process to resolve compensability, extent-of-injury and liability, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

28 Texas Administrative Code §133.307(e) (3) (H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution.

3. Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution. The requestor has failed to support that dates of service April 17, 2009, May 22, 2009, June 5, 2009, June 30, 2009 and July 21, 2009 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.
4. 28 Texas Administrative Code §133.305(b) states in pertinent part, "If a dispute regarding ... medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding... medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."
  - The requestor seeks reimbursement for CPT code 99243 rendered on March 30, 2009 denied/reduced by the insurance carrier with denial reason code "50 – These are non-covered services because this is not deemed a medical necessity by the payer. Unnecessary treatment (without peer review)."

Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issues of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution. The requestor has failed to support that date of service March 30, 2009 is eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

5. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestor seeks reimbursement for CPT code 99244 rendered on October 27, 2009, denied/reduced by the insurance carrier with denial/reduction code "B16 – Paymt [sic] adj new patient qual [sic] not found. Follow up visits in the consultations office or other outpatient facility for the purpose of providing ongoing care should be reported using office visits codes for established patients."

The AMA CPT Code Book defines CPT code 99244 as "Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family."

Review of the submitted documentation supports the requestor may bill CPT code 99244 for either a new or established patient. The documentation supports that the requestor billed for an established patient consultation. The requestor is therefore entitled to reimbursement for CPT code 99244.

6. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

Review of the submitted documentation finds that the MAR for CPT code 99244 is \$276.80, therefore this amount is recommended to the requestor.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$276.80.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$276.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

		March 21, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**